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Socratic dialogue and guided discovery in cognitive behavioral supervision

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Abstract

Supervision comprises systematic cooperation between the supervisor and supervisee in the form of a dialogue held in a secure, open and innovative manner. Cognitive behavioural therapy supervision is based on the same principles as therapy. To find associations, the supervisor uses guided discovery in which the supervisee may realize what he or she has not thought of and his or her understanding of the patient becomes deeper or may even change substantially. During the conversation, the supervisor uses questions to help the supervisee understand a wider context of case conceptualization, clarify adequate processes in treatment and realize transference and countertransference phenomena. The article presents several supervisor-supervisee conversations to demonstrate Socratic dialogue in supervision.

Introduction

Supervision may be viewed as systematic and goal-directed cooperation between the supervisee and supervisor. It is aimed at improving the therapist's competencies when working with particular patients (Linehan & McGhee 1994; Rakovshik & McManus 2010). For supervision to be helpful, it should be stimulating, safe, open, frank and innovative (Praško *et al* 2011a). The main goal of supervision is to enhance the value of the therapeutic process in the client's best interest. However, without the supervisee's support and development of his or her independence, personal style and therapeutic competencies, supervision would be nothing more than a check (Beidas & Kendall 2010; Vyskočilova *et al* 2011). Cognitive behavioural therapy (CBT) supervision is based on the same principles as CBT therapy. It builds on the key postulates of learning theories such as classical and operant conditioning, cognitive and social learning (Beck *et al* 2008; Persons 2008; Fairburn & Cooper 2011). Guided discovery aids in realizing the context based on both past experiences and new cognitive and emotional insight. Frequently, it helps the therapist conceptualize the patient's story, understand his or her situation and plan the optimal strategy, structure the therapy and lead it in the problem-solving mode (Davidson 2008). Especially, however, the therapist learns individual clinical and ethical thinking and decision-making (Praško *et al* 2011b). Supervision is a comprehensive process involving the patient, therapist and supervisor, each with one's own attitudes, experiences and typical thinking and behavioural patterns. Moreover, each of them is influenced by other contextual factors. The task of supervision is to draw attention to these factors and help the supervisee use them for the therapeutic process as well as his or her professional development. The supervisor may inform the supervisee

about how he or she understand what is happening in the therapy directly, from an expert's position (a vertical model), using tools such as explanation, instruction, examples or advice. Or he or she may place emphasis on the therapist finding it through his or her own thinking and experience (a horizontal model) (Praško *et al* 2011a). Modern CBT typically utilizes the latter approach, called collaborative empiricism. One of the main strategies used in the horizontal model is Socratic dialogue (Praško *et al* 2011b). A dialogue (*dialogos* in Greek, from *dialegomai*, to converse) is a conversation between two or more individuals. In their dictionary of sociology, Linhart *et al* (1996) defined a dialogue as "the most developed form of conversation, perceived as a sequence of utterances responding to each other, that is different from mere factual informing thanks to reflection of subjective attitudes, opinions and evaluation. It is a specific form of verbal communication, usually accompanied by some sort of personal determination". In current philosophy, it is sometimes used figuratively for the process of seeking the truth or sense through conversation. Socratic dialogue is the procedure used by the Greek philosopher Socrates to guide his disciples to knowledge through a dialogue. In such conversation, he used questions to help others to extend their view of a particular problem and then to change the view by a key opinion made by the disciple. In numerous early dialogues, Socrates talked to people firmly persuaded that they definitely knew something. First, Socrates disputed their supposed knowledge with his questions and then led them to deeper understanding and view. Thus, guided discovery is a method of holding a dialogue with the other party that helps the interlocutor discover a new perspective on a particular problem. In his "Memoirs of Socrates" (Xenofón 1972) Xenophon gave numerous descriptions of Socrates' open-minded effort to influence his fellow citizens. With the exception of a longer dialogue with Euthydemus, however, there is no Xenophon's dialogue with more extensive examples of the typical *elenctic* (refuting an argument) and *maieutic* (pertaining to midwifery) method of Socratic questions. But both may be found in Plato's works. Plato mentioned Socrates' strategy of holding a dialogue in the Meno, Theaetetus, Theages and Clitophon dialogues (Platón 1994, 1979) and, partly, in the Apology of Socrates. A key text demonstrating the dialogue method is the part on maieutics, Socrates' "art of giving birth" in Plato's Theaetetus (Platón 2002). In a logically conducted dialogue, Socrates uses questions to guide his partner to discovering a certain viewpoint until suddenly, and often unexpectedly, ideas are illuminated. In modern philosophy, the method was continued by Leonard Nelson, a German philosopher (Nelson 1992). According to Nelson, no external authority may be let into thinking since this makes formation of one's own opinion impossible. The stress that is put on formation of one's own opinion stems from Nelson's conviction that unlike natural science, philosophical truth is actually not a matter of objective facts but a matter of opinion (Nelson 1992). Already at that time, Nelson thought that the teacher's most important task is to influence the student so that in fact the influence is minimal (i.e. limited only to strengthening the thinking itself). This approach is still used in modern education. Socratic dialogues are used in both tertiary and secondary education, particularly for mathematical or logical topics (Kolář & Šikulová 2007). Further, Socratic dialogues are common in psychotherapy and supervision (Friedman 2000; Gantt 2000; Praško & Vyskočilová 2010).

In Socrates' dialogues, two elements may be distinguished – *elenctic* (refuting) and *maieutic* (bringing the interlocutor to a particular piece of knowledge). Both elements were recognized and designated by Hegel in his History of Philosophy (Hegel 1965). First, he mentions the *elenctic* element – Socrates inculcates people with distrust of their assumptions, guiding them to realization that to really understand, they must think. Socrates in fact personifies that Greek waking from a tradition (or myth) in which answers are known before questions are asked (Patočka 1999). Through constant, neverending (as at any moment, Socrates knows that he knows nothing) dialogue, questioning, exploring his own thoughts and thoughts of those close to him he fights for a true view (Xenofón 1972; Patočka 1991). The *maieutic* element is the assisting into the world of the thought which is already contained in the consciousness of the individual – the showing from the concrete, unreflected consciousness, the universality of the concrete...

According to Kanakis (1984), the most important element of Socrates' method is aporia (i.e. doubt, puzzlement, objection, perplexity, difficulty, confusion) which occurs when the interlocutor admits that he or she does not know the answers to Socrates' questions and is puzzled since initially he or she was sure to understand the problem. To make the interlocutor explore the problem once again, Socrates has to guide him or her to aporia using questions. Only after further thinking about the presented issue, the interlocutor may come to better understanding. The aim of Socratic strategy is not the correct answer since ethical questions, mostly asked by Socrates, tend to be open and the answers cannot be simply labelled as right of wrong. The aim is to teach the partner reflexive and critical thinking. For Kanakis, the elenctic part of the dialogue (with the philosopher proving that the interlocutor does not know what he or she thought he or she knew) is a stimulus supposed to arouse the other person's desire to learn the answer to the question asked. The resulting aporia is felt as a lack of knowledge, arousing a desire to overcome the gap. Aporia provokes the interlocutor's motivation to keep thinking.

Group Socratic dialogue (e.g. in group supervision) is based on several essential principles, giving the dialogue its form. The Socratic method is only effective if these principles are strictly adhered to. Therefore, Socratic dialogue cannot be conducted "just partly".

- *Thinking is not intuitive* – it has its own regularities that we utilize (therefore, therapeutic, supervisory, philosophical as well as mathematical dialogues are possible). The main principle is to guide the interlocutor to individual thinking. Thus, Socratic dialogue should be mainly used for dealing with problems that do not require any other investigations at that particular moment, such as examinations or history taking, although the need for them may stem from the dialogue.
- *The thought process is not subject to authorities* – the Socratic therapist consciously resigns from his position of an authority. From a distance, he or she guides and ensures that the patient, supervisee or group keeps to the path of sincere argumentation and thinking. His help is mainly in the form of asking questions and providing support to those who are thinking.
- *Each participant, inside him or her, already knows* about potential solution of the problem even though he or she is still unaware of it. In each participant's utterance, there is a "grain of truth". By applying this principle, the therapist guides the patient or group to listening to contradiction and contrast, paying attention to others' looks, careful judgements and tolerance. This is also true for the therapist (or supervisor). He or she must hold back his or her tendency to "help" and give advice. Although some opinions may first seem to be ridiculous, stupid or immature, he or she should try and seek the "grain of truth" in them.
- *Dialogue as a method of thinking.* In everyday life, people mostly communicate ready-made opinions to each other or, sometimes, even things that stem from longer thinking. Socratic dialogue, however, assumes thinking during the dialogue. The other person or group is an auxiliary tool for an individual's thinking. In the discussion, one considers carefully what to say, makes sure that he or she has understood the other person well and that he or she states his or her opinions clearly enough. Dialogue of two or more people makes them take a critical perspective.
- *The aim of dialogue* is, as a rule, to find a new view. It is mostly a consensus reached through discussing all possible opinions.

Group dialogue does not aim at reaching one's goal immediately or finding some "general wisdom" but at searching for the answer together. The participants build on their own experiences, not opinions of authorities.

There is also a pre-therapeutic tradition of Socratic dialogue in modern science and 20th century philosophy. Martin Buber, an existentialist philosopher, described dialogue as the most important form of a close encounter between people that allows opening of one's own dimension, depth and creativity in thinking as freedom and security in the relationship are felt (Buber 1995). In 1923, Buber published his best-known essay called I and Thou on philosophy of an individual relationship with another person. According to Buber, dialogue is mainly expression of a relationship allowing a person to multiply one's awareness and creativity. The sense of dialogue, however, is not only intellectual benefit but especially recognition of others as humans and partner. In Buber's "I-It" relationship, an individual considers other things (and people) as objects to be treated according to his or her needs, studied, manipulated and used for his or her purposes as needed. In the "I-Thou" relation, on the other hand, independent autonomy is recognized of the other person as a free ("detached") being that cannot be treated as an object. If one wants to meet and approach the other, he or she has to address him or her and to wait for what the other person is willing to say about himself or herself. A typical manifestation of the I-Thou relationship is both the need for privacy and intimacy and respect for them.

Another influential person addressing dialogue groups was David Bohm, a British quantum physicist. Apart from physics, Bohm contributed to philosophy and meaning of language, describing the great potential of group dialogue for creativity development (Bohm 1996). He was persuaded that the process of dialogue in a group has great potential for not only improving understanding but also creativity, generating important stimuli for research. Bohm defined several characteristics of creative dialogue reminding us of principles in Balint groups (Bohm 1996): (a) during dialogue, there is no need to come to any conclusions; the discussion should be free with an open space; (b) during discussion, other opinions, views or ideas are neither judged nor attacked; nothing is "good" or "bad"; (c) the participants are willing to give up evaluation of their ideas and decisions to prevent "whose idea is the best" competition; (d) opinions and stimuli communicated by others are not their property but may be used for further development and linking of ideas.

Similar to Buber, Bohm was persuaded that dialogue work helps overcome blocks in thinking and inhibitions and makes people feel natural and open to views they otherwise would or could not see. Also John Dewey (1933), a prominent American educational reformer, stressed that the open air of public discussion and communication is an indispensable condition of the birth of ideas and knowledge. His idea of effective learning is in particular associated with a learning-by-doing approach. He stated that the participants learn in accordance with the level of their participation. One of the best ways of how to understand something is having to explain this to others. We learn by active listening.

Guided discovery and Socratic dialogue in therapy

Cognitive therapists named one of the most effective strategies – Socratic dialogue – after Socrates (Beck *et al* 1974; Ellis 1962). Guided discovery and Socratic dia-

logue as strategies for conducting dialogues have been used in many other psychotherapeutic approaches, in particular person-centred psychotherapy (Rogers 1967). Carl Rogers claimed that if the therapist carries on an empathetic dialogue with the patient, is congruent, accepting and empowering the patient, he or she enables the patient to understand deeper meanings of experience, sense and relations. In cognitive behavioural therapy, guided discovery is an essential part of communication with patients, considered to be more important than psychoeducation (Padesky 1993; Praško *et al* 2007). Questioning of maladaptive thoughts and attitudes by Socratic dialogue is one of the most important strategies for change also in supervision (Praško & Vyskočilová 2010).

When working with automatic thoughts in cognitive behavioural therapy, the therapist's task is to teach the patient how to critically assess his or her thoughts, that is view them as hypotheses that may, but do not have to, be true. To judge their veracity from various points of view. By carrying on Socratic dialogue with the patient, the therapist teaches him or her how to conduct it with himself or herself (Padesky 1993). Another important approach in validating the patient's convictions is their empirical testing (Beck *et al* 1974). Both co-workers (the therapist and the patient) together plan an experimental situation in which validity of a given assumption may be verified so that it is immediately known whether it is, or it is not, valid. Beck *et al* (1979) suggested that the therapist and the patient form something like a "scientific team" in which, together, they would assess the validity of automatic thoughts. Unlike Ellis' method of confrontation (Ellis 1962), according to which the therapist uses the strength of his or her arguments to persuade the patient that his or her thoughts are irrational or illogical, Beck recommends that the therapist carries on Socratic dialogue with the patient to teach him or her how to ask oneself certain questions and based on them come to a conclusion on whether his or her negative thoughts are valid or not. With adequate questions, discussion about a certain assumption may be started with the patient. Thus, the aim of the dialogue is not to persuade the patient that his reasoning is wrong but to show him or her that his or her way of thinking is not the only possibility and that a particular situation may be assessed differently. As in Socratic dialogues, rather than finding the "truth", learning how to think about problems in a differentiated way instead of jumping to conclusions is more important. It is very important to guide the patient to ask himself of herself similar questions. Socratic dialogue should never turn into disputation, with the therapist proving the patient wrong and the patient defending veracity of automatic negative thoughts. It is also important that the therapist avoids answering inductive questions instead of the patient. Although sometimes the therapist may feel that he or she knows the adequate and reasonable answer to automatic thoughts it is better to be patient and leave the patient enough time to come with his or her own answer that is convincing for him or her. The aim of this way of conducting a dialogue is not only to teach the patient to find a reasonable answer to automatic thoughts but especially to teach him or her how to ask these questions to oneself and to use them to question one's automatic thoughts (Praško *et al* 2007).

Thus, the sense of Socratic questioning is to use appropriate questions to reveal something that the patients already knows but has not considered or has forgotten. Through sensitive questioning, the therapist helps the patients to better use what he or she already knows, to figure out alternative ways of explaining known facts and to find new potential solutions to his or her problems. The aim of the questions is to make the patient realize as many facts as possible and to draw his or her own conclusions that would be remembered and convincing. A "good" Socratic question means that (a) the patients is able to answer it, and (b) the answer will show him or her new perspectives (other options).

The Socratic method is an ideal tool for making patients consider various options that so far have been beyond the limits of their thinking, and develop a constructive alternative view of a particular situation or event. Good Socratic questioning takes place in an atmosphere of a good therapeutic relationship. The therapist's effort is to express warmth, understanding and nonjudgmental attitude to relieve the patient's fear and helplessness and to support his or her engagement, lateral thinking, creativity and remembering. The patients should have a feeling that his or her perspective is "interesting", not "wrong" and his or her exploration of new possibilities is appreciated and taken into consideration, not critically disputed, by the therapist.

There is a common erroneous belief that the CBT therapist is like an infallible lawyer in a courtroom who never asks a question without knowing the answer and suddenly reveals "the truth" using a few brilliant questions. It is of interest to note that A. T. Beck reported that his role model was Lieutenant Columbo, a TV show character. His gentle – never rough or omniscient – investigative style corresponds with an attitude of genuine curiosity and respect for others. Such an attitude is absolutely essential for "good" Socratic questioning. The style and sense of Socratic questioning was most thoroughly analyzed by Padesky (1993). She underlined the important difference between using Socratic questioning to *change minds* and using it to *guide discovery*. According to Padesky, the therapist attempting to "change minds" actually suggests that the patient's thoughts are illogical, whereas the therapist "guiding discovery" opens new possibilities for the patient. The key to the latter approach is an attitude of genuine curiosity on the therapist's side. In his commentary on Padesky's opinions, Teasdale (1999) noted that at a psychological level, "changing minds" invalidates specific thoughts or meanings, while "guiding discovery" creates alternative mental frameworks. Thus, the CBT therapist should strive for "guided discovery" not only

from a position of curiosity but also from a position of humility. This enables him or her to accept the fact that often he or she may learn something from the client rather than suggesting that he or she knows (or should know) the right answer. This is how the therapist can avoid falling into a trap of "changing minds".

The ultimate goal of therapy is that the patient becomes both Socrates and his disciple. He or she should learn to stand back, review the situation and develop new perspectives. For learning these skills, a daily thought record is invaluable. The patient learns how to identify his or her own emotions and key cognitions, to explore the validity of the thoughts and to synthesize new attitudes. With rehearsal, this procedure may become second nature for the patient.

Guided discovery and Socratic dialogue in supervision

Socratic dialogue and guided discovery are strategies frequently used in supervision as well. Instead of presenting facts to the supervisee, the supervisor uses questions to help him or her discover them (Praško *et al* 2011a). As in the case of therapy, inductive questions are used, e.g. "Do you have a feeling that it might be somehow related...?", "If we admit that it is as you say and, at the same time, what you said a while ago is true, then it all leads somewhere... What do you think about it?", "It just came to my mind... How does the patient's wife feel in that? What do you think?"

Guided discovery may aid in establishing the supervisory relationship – produce an atmosphere of security and understanding (Bennett-Levy 2006; Greenberg 2007; Thwaites & Bennett-Levy 2007; Vyskočilová & Praško 2011). The following example clearly shows how the supervisor helps to create an atmosphere of security (Vyskočilová 2012).

Lucie (supervisee): There is this young woman, Miss K, in my ward and she just drives me crazy. I know this should not happen but I simply cannot help. She is terribly insistent, constantly giving orders. Whenever I walk along the corridor, she demands something or complains about something. She does that to Petr (Lucie's colleague) as well. I would like to learn what to do not to be irritated by her since otherwise I would not be able to help her. When I talk to her on my own I am not patient enough and I cannot listen to her much as she annoys me. Normally, this does not happen to me and I have good relationships with the other patients.

Jiří (supervisor): If I get it right, you mostly manage to establish good relationships with your patients but now there is a patient in your ward who is extremely insistent, even outside sessions, and that irritates you. You cannot be patient enough with her any longer. You feel sorry about it and worry that you will not be able to help her. But you would like to help her if I understand it right. At the same time, you are angry at her, aren't you? (*The supervisor summarizes what he heard from the therapist, giving her a feeling of acceptance – he listened carefully – and security – he understands her.*)

Lucie: Exactly... The patient suffers from borderline personality disorder and she annoys everybody, in particular her relatives, abusing them on the phone all the time. On the other hand, she helps other patients in the ward, lending them her mobile phone so that they can make phone calls, she is committed to others and can be sensitive. I can see that as well, she is not bad all the time. Yet I am already allergic to her. I do not know how to treat borderline patients. I understand her troubles but why does she trouble other people?! The other day in the corridor, she was yelling at her mother on the phone, calling her a "bitch" and "cunt" because she had forgotten to bring something to her. I do not mind offensive language much but her mother tries to help her all the time, visiting her every day. Moreover, she scared the other patients who were afraid of her. I am simply not patient enough with borderline patients and they make me angry immediately. It is my fault. Petr is less angry and more sympathetic. But I am not. Yet I would like to learn that somehow because I know that I just fail to meet the patient and do not help her at all. Then I think I am a bad doctor... (*Apparently, the therapist feels secure enough to talk openly. She is aware of various aspects of the relationship with the patient and starts with self-reflection.*)

Jiří: You seem to think about her a lot if you realize not only that she annoys you but also that she is committed to others and can be sensitive. And I understand very well that you are annoyed by her disrupting the entire ward. It is my experience that such patients annoy most people. But others tend to accuse the patient of all the trouble and never doubt about themselves the way you do. I consider your attitude fairer. You also wish to change it, learn how to treat her so that she benefits from that. I like your ethical thinking. (*The supervisor first reflects on the ambiguity of her relationship with the patient, then enhances the secure atmosphere, puts himself in the therapist's shoes, expresses sympathy for her negative emotions and normalizes the negative reactions. After the secure atmosphere is created, he appreciates her ethical attitude, encourages and rewards her tendency to seek the way to the patient.*)

Lucie: That's right. In some respects, I can see that she is very nice. That's when she helps others. I also do not want to be like other therapists, making sweeping judgements about how terrible borderline patients are. What makes me most angry about her is that I cannot help her. When manic patients swear and cause mayhem I am much nicer to them than to her. And drugs help there so they calm down. But in her case, drugs are not much effective and she does not accept my attempts at psychotherapy at all. She says she has already had sessions with at least 5 experienced therapists with no results. She has made it clear that I am young and inexperienced... If I could establish a contact with her and motivate her it might be better for us both. I don't know if I could help her but at least we might try. Now she turns me down and at the same time, she insists on stupid stuff – for example she changes the

list of people who may be informed about her condition several times a day. (*The therapist continues to open up.*)

Jiří: Nice of you to think about it that way. It is understandable that she makes you angry when she refuses your attempts at therapy and at the same time wastes your time by demanding unnecessary things. I am even more pleased that you feel like helping her even though she made you feel that you are not that experienced. Let's think together about how to motivate her, shall we? (*Once again, the supervisor strengthens and reacts in an empathetic manner. He underlines one of possible problems in the relationship – the therapist being depreciated by her patient – but in contrast to the therapist's desire to help. Then he encourages the possibility of searching for a solution, with an ethical goal – the patient's benefit.*)

Lucie: She might accept if we just talked about her childhood. When I examined her I went through that too fast as there was not much time left after she had talked about her current problems for a long time. I actually do not know much about her, apart from frequent conflicts with her father, friend and at work. I know almost nothing about her growing up. And I saw her father so I assume it must have been difficult for her. Now I realize that in fact I cannot understand her because I know so little about her development. She might be pleased if we talked about it. (*The therapist realizes that in fact she has not completed case conceptualization – one of basic competencies – as she knows little about the patient's childhood. She feels so secure that she has stopped accusing herself and thinks aloud, self-reflecting.*)

Jiří: I can see that you have found a way of how to improve the therapeutic relationship with her and, at the same time, how to understand her better. It might be true that her childhood was really difficult... Do you think that a sensitive discussion about her childhood may help the patient feel more accepted? (*The supervisor encouraged and confirms, using an inductive question to define the patient's potential schematic problem.*)

Lucie: Yes, she keeps insisting that we all devote little time to her. The staff, me, her family... Also her friend... I guess you are right, she does not feel accepted... She does not think that she is accepted anywhere and that's what all the conflicts are about. And I cannot accept her either... It is difficult for her... That's why she tries to help others so much. And that's why she gets so upset when someone does not pay enough attention to her. (*The therapist develops a hypothesis about the patient's core schema, searching for evidence based on the facts she knows.*)

Case conceptualization is the ability to understand problems and symptoms from the perspective of its history and current context. The essentials of this skill are based on theoretical study but its development is only possible through practical experience of working with patients, most significantly developed by systematic supervision (Armstrong & Freeston 2003). With guided discovery, it is possible to help the supervisee better understand his or her patients (Vyskočilová 2012).

Jiří: Last time we discussed Miss K who made you angry by being too insistent. Finally, we concluded that she possibly did not feel accepted. You said that you would try to talk to her more about her childhood. Do you feel like talking about that today or are there other things that you would like to work on? (*The supervisor providing continuous supervision offers to continue with the topic from the last session but also allows the therapist to choose the topic freely.*)

Lucie: Although I would like to talk about my new patient today I also need to discuss my work with Miss K. I have to make up my mind... There is definitely not enough time for both... So let's continue with Miss K since there has been some progress. But today I need to discuss which strategies to use next. Maybe even try something with you because I have never worked with a person who has been sexually abused in the childhood... It would help me to rehearse that. Do you think it's possible? (*The therapist specifies an order.*)

Jiří: Definitely. I like that you specify what you would like to do today. I think that makes sense. And I am glad there's been some progress. I wonder what it is. So what did you find out and what was talking to her like? (*The supervisor shows appreciation and then focuses the session, first on clarifying conceptualization and therapeutic relationship.*)

Lucie: I simply sat with her and offered to talk about everything from the very beginning, from her childhood. And she agreed. She also said, in a mocking tone, that we could have done that much earlier. I did not react to that, though. Then, all of a sudden, she burst into tears and said that nobody believed her. That her brother touched her private parts and later raped her. She only disclosed that to her parents when she was adult but her mother did not trust her and her father came down on her for being a liar. She poured out her story to me and then cried, looking at me and waiting for my reaction. I felt that she was desperate and yet ready to fight if I didn't tell her immediately that I trusted her. So I did tell her that I trusted her and asked if she wanted to tell me more. She said that she did not and that it was enough for her to know that I trusted her. And she ran out from the room.

Jiří: So after all, you've gained her trust. That's great. It is good that you told her that you believed her... (T*he supervisor confirms the therapist.*)

Lucie: On the same day, she returned to ask if I had time to hear more from her. I hesitated about accepting the fact that we would talk whenever she liked. On the other hand, it was clear that she wanted to talk about such a serious thing and that's why I agreed. She said that since she had been eight, her brother had regularly touched her private parts, threatening to kill her in case she told someone. Repeatedly, he was fingering her vagina, making her touch his penis and stimulate him. She tried to avoid him as she could but he always managed to find her. Then he raped her when she was thirteen. She told her parents as much as ten years later as she was terribly ashamed of that. But they did not accept it. Her mother did not believe her and her father started to yell that she was not telling

the truth and that she had always lied. According to them she would have told them immediately if that had been the truth. When she talked to me she almost constantly cried or was angry – at her parents and brother. She also said she would have killed the bastard or cut off his cock if she could. According to her he is in prison for deception now and it serves him right. I did not know what to do about her being so angry and swearing. Apparently, she needed that a lot. But when I hear so much hate in someone's voice it kind of deadens... It makes me feel helpless but that's beside the point. When she cried I was afraid to approach her as she could explode again. I was just sitting there and listening to her. I could not really step in.

Jiří: I can see that the two of you have made a lot of work. She could open up to you about such painful memories. When recalling she is full of conflicting emotions that alternate. No wonder it deadened you at moments as you've just said. I also think there is little to add to such a story which typically touches a therapist as well... Last time we said that she might not feel accepted which results in both her desire for attention and her anger whenever she feels that someone important for her ignores her. Do you think it is more understandable now that you know what she has been through? (*The supervisor appreciates, expresses his understanding, normalizes. Then he uses an inductive question to direct the therapist to conceptualization of the case.*)

Lucie: I still need to discuss the childhood with her more so that together we would recall not only traumatic memories but also some good things that we could build on. What she experienced, however, is sufficient enough for her not to feel accepted and understood. I will use the downward arrow technique to identify her schema and then I will talk over the consequences of the schema. I think it will mostly be concerned with her conviction that she is not loved and hurt by others. In that case, the compensatory strategies in her behaviour are understandable, such as her being desperate for attention and angry if she is not getting it. I think I understand her more after she has opened up to me. I think that now I should continue with talking more about the trauma and using imaginal exposure... On the other hand, I am a bit afraid of her fierce reaction and I do not want to upset her even more... I also do not know how to anchor it and calm her down. Would you help me with that? By explaining what to do or rehearse something? (*The therapist summarizes conceptualization and considers other strategies – sharing conceptualization with the patient through work with a schema. The she returns to the original order – to find out more about the strategy she would like to use, or possibly rehearse it.*)

Jiří: I like the way you gradually conceptualize her story. If you talk this over with her you get a good basis for the two of you being able to process her trauma in imagination. You are probably right that Miss K's reaction might be very fierce. I think that imagery rescripting of the trauma would be most suitable. I am sure you remember that from your training. First, you have to create an atmosphere of security and acceptance with the patient, give her the power of control, that is she may stop the imagination at any time. Initially, you explain to her what you will do. The next step is imagination of the traumatic event as such. For the first time, it is usually short as it is difficult for the patient who tries to avoid it. In the third step, you create a protector. This may be someone she trusted at that time, or it may be her as an adult or even you. The protector enters imagination to protect or possibly comfort her. Would you like to rehearse? As the therapist? Or in the role of the patient, with me being the therapist? (*The supervisor appreciates, expresses understanding of the therapist's concerns and structures the possibility of rehearsing the strategy she wanted.*)

Lucie: I guess I will try the therapist's role straight away. I believe I will manage. I already tried that during my training and was quite successful I think. After all, we can stop at any time and remodel if I don't manage. Okay? (*The therapist encourages herself to play roles.*)

Guided discovery strengthens the supervisee's self-reflection. Self-reflection is a complex process (realizing the therapist's own cognitions and attitudes, emotions and behaviours toward the patient, and how these are related to his or her personal core schemata and conditional assumptions, and their potential modification when working on oneself or in supervision). From the CBT perspective, self-reflection also requires ability to reflect one's own skills and maintain the ability to apply them naturally and continuously, at any time necessary for the patient's therapy (Bennett-Levy 2006; Vyskočilová 2012).

Veronika (supervisee): I have this patient, Mr V, he is depressed, not severely, but the problem is that he never does his homework, not at all. Every time I try to plan things with him as much as possible, explaining why and how he should do a particular task so that it is sensible, and asking about potential barriers. He always nods in agreement but never does anything. And during the following session, he always says: "You see, doctor, I know I should do it because it is for my own good but then I just put it off, I somehow cannot force myself to do it. I do not know how to do it. How do I force myself to do it? "My feeling is that he always passes the buck to me. How do I explain to him why he is unable to force himself? I simply think he is lazy and plays games with me.

Karla (supervisor): Yes, I know what you mean. You do your best to help him, think about how to make things easier for him, explain the point of the task, even ask about potential barriers preventing him from performing the task. And he promises all of that to your and then does not complete the task and looks helpless. No wonder you are dissatisfied with that, or even, as it seems, a bit angry. (*The supervisor supports the therapist – this is a core competency of supervision – and gives positive feedback about various specific competencies of the supervisee concerning homework assignment. She is empathetic about the problems that occur.*)

Veronika: Sometimes I think I will pack in homework in his case. I put pressure on him in vain and then I am just angry and it's no use (*The therapist feels secure enough in the therapeutic relationship to be able to reveal her scepticism concerning continuation with an important part of the therapeutic plan.*)

Karla: That might be a solution... Before you make a decision, though, we will try to map what the patient is probably going through. What is it that prevents him from completing the tasks? What are the obstacles? Are there any attitudes or expectations related to that? Is this because he does not trust himself? Let's hypothesize about schemata potentially affecting his behaviour that impairs this part of therapy. (*The supervisor offers an alternative strategy requiring the therapist's use of conceptualization skills and a specific competency of working with schemata in case conceptualization.*)

Veronika: I have already talked to him about that, offering him the hypothesis that it might be due to certain thoughts that activate whenever he wants to do homework and that it activates his feelings of incompetence that occur in other situations as well. When I asked him what he thought he only said: "I have no idea. You're an expert." So he won again! (*The therapist tried to use conceptualization to understand the patient's lack of cooperation but she still felt blocked. Countertransference manifestations are also apparent.*)

Karla: Why don't we brainstorm as many ideas as possible about how to change the situation? By the way, it is also my experience that whenever I ask some patients who are very avoidant or depressive why they do not do their homework they usually say that they "do not know" or "do not have energy to do that" of that "it is no use". Then, for a while, I feel my effort to get somewhere is pointless. The question is: what to do in such a situation? I guess the two of us might try to find a way of asking the patient in such a way that he almost does not feel guilty and feels more like an "expert" when responding. In that case we might find the cause. What do you think?

Veronika: You are right. I ask him why he has not done homework and he must feel like talking to a teacher at school immediately. I did not realize that. And paradoxically, his mother was a teacher and she constantly chased him about various tasks and criticized him. I may remind him of his mother... I hope I don't (she laughs). He may feel helpless when he sits to do the homework. Actually, I have never discussed his feelings related to homework with him. I expected him to make excuses straight away. We also never talked over the thoughts that occur to him when I assign homework. What is happening with him when he promises everything? Is this because he is afraid of telling me that there's too much? Is he afraid of admitting that he does not understand something? Is it because of his experiences with his mother? I hope the brainstorming will help us find a way of how to encourage him more. But I must admit that when I am with him, I have serious doubts about myself. Am I good enough to be a therapist? I am often impatient with him. Sometimes I do cognitive reconstruction instead of him when he does not say anything. Then I comfort him when he says that he is useless because he has not come up with anything. At moments I "save" him. Then I am angry at him for not doing anything and using it to outwit me: "Look at how useless I am". Then I am helpless. It is clear that what I do is good for nothing and it cannot help anyone. (*The therapist has revealed some countertransference patterns she noticed in her reactions to the patient. By this, she has shown the core competency of self-realization.*)

Karla: Very good self-reflection! I must say you surprised me by how good it is. Especially as I know that you are only in the second year of your training. Keep it up! You also asked yourself some important questions. What is actually happening with the patient when he promises to complete his tasks and what is happening with him when he sits to do homework? It seems to me that more careful mapping of his thoughts, emotions and behaviour in such situations might help to understand him better. Maybe you could also deal with your self-doubts a bit. Are your skills really so poor that you have to have serious doubts about yourself? There might be some rational answers that you could use to reduce your self-doubts. I think you are able to do it well. (*The supervisor uses the basic skill for establishing the supervisory relationship. She strengthens the therapist's core competency, self-reflection. Moreover, the supervisor guided the therapist to try a specific CBT skill, cognitive restructuring, in order to change her self-doubts that may interfere with her work with difficult patients such as Mr V.*)

Veronika: Do you think I should think of a list of the pros and cons of my therapeutic work? (she laughs) Actually, I cope with my work most of the time. Just sometimes, like now, things do not go well. Then I unnecessarily succumb to self-doubts. Fortunately, it only lasts for a short while and then I overcome that. I think it is better to solve problems than to ruminate about my mistakes. But you're right, it is related to my attitudes toward you that I should process. (*The therapist reacts to the supervisor's support by mobilizing her core competency of rational reaction and applies it on herself.*) It occurred to me that maybe I should record my sessions with Mr V so that you know exactly what I do with him. Would you have time to listen to that?

Karla: I will be happy to listen to the recorded session with Mr V to give you a more specific feedback. However, you need to ask for informed consent. Also, you must be sure that you are willing to be exposed to that and that we will listen together to what you say to your patient. But I fancy that a lot. It is a sign of your courage and fairness. These are qualities that I noticed earlier. (*The supervisor has decided for direct work with a recording. She mentions the ethical aspect of that and appreciates that she has come up with the idea.*)

If it is beneficial for therapy, the supervisor may serve as a model for the therapist in how to reflect one's own deeper attitudes. By his or her own self-disclosure, the supervisor usually inspires the supervisee not to be afraid to self-disclose and induces his or her guided

discovery of his or her own thoughts, attitudes and motives. The following extract describes self-reflection at the beginning of clinical supervision in a novice therapist undergoing cognitive behavioural training.

Olga is a 28-year-old psychiatrist who comes from a farming family living in a small village in Slovakia. Since she is the oldest daughter, she took care of her two younger brothers for her entire childhood. Olga's mother, an efficient, assiduous and active woman, has always dominated the family. These traits were inherited by Olga who worked her way up and graduated from a medical school. The family is very proud of her. One year after completing her studies she moved to the Czech Republic to start her career in clinical practice, get married and enter CBT training. One of her patients is a 24-year-old Aleš. He is of Romany ancestry and he grew up in a large and very poor family. As a child he often starved, was beaten up by his older siblings and had to wear loose-fitting worn-out clothes. The family was dominated by the father, an alcoholic who was frequently jobless. The mother was submissive and devoted, caring for her 6 children as well as she could. She only occasionally stood up to him and then was beaten up. Aleš also worked his way up and graduated from a technical university. But he remains without a partner. He became estranged from the Romany community and feels not good enough for white girls. For some 4 years, Aleš has suffered from frequent aggressive obsessions as part of obsessive-compulsive disorder. Roman, a 35-year-old clinical psychologist and Olga's supervisor, comes from Prague where he grew up in plenty, as the only child in an intellectual family of generations of university graduates. His parents always competed with each other to see who was right or more competent, who would have the last word, etc. Despite constant arguments they stayed together and basically got on well. Roman got his degree easily, with no effort. He never worked his way up but spent time with hobbies and friends in Prague pubs. Currently, Roman is without a partner. She left him for another man about 3 months ago, after a long relationship. Olga and Roman work in different wards of the same facility. They seem to impress each other. Once a week for 4 months, Roman has supervised Olga's therapy of Aleš. Roman is aware of the fact that Olga has only begun her psychotherapy training and clinical practice and he also realizes that the patient, Olga and himself come from rather different environments affecting the basic attitudes and needs, coping mechanisms, therapy goals, ability to self-disclose and male-female relations. Moreover, each of them is currently in a different life situation which may also affect both supervisory and therapeutic as well as the patient's attitudes. He also realized that Olga is very attractive and that this may influence both his supervision and Aleš's relationship in therapy. To avoid false preconceptions and to understand Olga, and Aleš in the background, as much as possible, in addition to conceptualization of Aleš's problems and supervision of the therapeutic approaches used, Roman has put much emphasis on Olga's self-reflection and guided discovery of her own attitudes towards Aleš and herself since the very beginning. As all the participants have different cultural and psychosocial backgrounds, Roman is persuaded that self-reflection will be important for both Olga and himself since it produces an open basis to build on in further supervision and possibly therapy.

During the first supervision session, Roman and Olga discussed and agreed on a supervision contract. They openly discussed the conditions and limits and stressed that both sides need an open feedback, try to be honest in any case and will get rid of any "game-playing" should this occur. Roman used self-disclosure as an opportunity to normalize self-disclosure and personal reflection in the supervisory relationship by being an example. Roman said that although he was impressed by Olga he would do his best not to let this interfere with supervision work. Olga admitted that Roman was also attractive for her but she had never thought of flirting because she had a nice relationship with her husband whom she loved. However, she was concerned about his intelligence and sophistication, and about appearing stupid to him because she was not that well versed. She admired him both as a therapist and supervisor, preventing her from disclosing potential problems. Bilateral self-disclosure helped to alleviate Olga's feeling of vulnerability. Roman also said that this supervision was a personal challenge for him since he himself had to deal with the fact that he liked Olga as well as with another attitude – to people who worked their way up. In fact he admired Olga for that. Nevertheless, since his school years, he had been prejudiced against people who try hard and had considered them swots. But he realized that the attitude "smart people do not have to try hard, only dull people try hard" was wrong and "immature", protecting him from the fact that he had never been determined enough to try hard. He also told her that he admired her for how hard she had worked in her life and for what she had accomplished. His grasp of culture actually was not his achievement but simply resulted from the fact that he had been born to a family in which this was considered normal. What was not considered normal, on the other hand, were hard work and strong will, normal things for Olga. The contract encouraged Olga to self-reflection and included a request for discussing personal experiences in both therapy and supervision. Olga informed Roman that she had only a brief therapeutic experience, especially when working with people suffering from obsessive-compulsive disorder. Roman realized that if his supervision was to help both Olga and Aleš, cultural and social differences should have been included. Therefore he asked Olga about her attitude towards Romany people. She said that she had no problems with Aleš whom she considered very intelligent and whom she admired for having worked his way up. However, during her childhood in Slovakia, she had many Romany schoolmates whom she disliked. They were often dirty, wore tattered clothes and had fleas that she sometimes got at school. Now, in adulthood, she thinks that she has no prejudices, understanding that Romany people did not choose their fate, had very complicated history and are under the pressure to adapt to the majority. However, she is a bit mistrustful of them, fearing they may rob her. She has no such feelings with Aleš. Roman admitted to have similar mixed feelings about Romany people. Rationally, he is persuaded that they are people like him, he does not think he is more valuable and he also realizes that maladaptive behaviour of some of them stems from the history of enforced coexistence with the majority. On the other hand, he must admit to a prejudice, mostly in connection with their criminal behaviour, filthiness, cunning and intelligence. As a child, he himself was beaten up and robbed by three Romany boys. On the other hand, most violence he has encountered was caused

by white people. This part of the first supervision session made both Roman and Olga well informed about their attitudes and cultural beliefs concerning Aleš's background. Then Roman asked Olga about her opinion on family influences on Aleš's attitudes. Olga especially notices that Aleš tries hard as he probably has all his life. Nevertheless, it is obvious that his education put him outside the Romany community and he has failed to join the white community. But Olga is very impressed by his efforts since she has also tried hard for all her life. And he had to work his way up under much more difficult conditions than she did.

CONCLUSION

Socratic dialogue is an important tool in cognitive behavioural therapy supervision. During the conversation, the supervisor uses questions to help the supervisee understand a wider context of case conceptualization, clarify adequate processes in treatment and realize transference and countertransference phenomena.

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